STUDY OF OLDER ADULT PREFERENCES (SOAP) FOR INHALER DEVICES

Section One – (Demographics and Medical history):

1. Age: _____ years old

2. Gender: □ Male □ Female

3. Living Status: □ Home □ Nursing home □ Assisted living

4. Do you require any assistance with activities of daily living including cooking, paying bills, medication administration and other activities?
A. no, I perform all of these activities myself
B. yes, I have assistance with some of these activities. Please specify what activities you require help with: _____.
C. yes, I require assistance for most or all of these activities.

If answering B or C, please specify who provide you the assistance you require:
□ Family member or spouse □ Healthcare assistant
□ Others, please specify_____.

5. Highest level of education completed:
□ Elementary School
□ High School
□ College
□ Bachelor's degree
□ Graduate degree

6. Has your physician ever told you that you have any of the following conditions? (Check all that apply)
□ Stroke □ Heart disease □ Parkinson's disease □ Dementia
□ Alzheimer's disease □ Hand Arthritis □ Seizure □ Hearing loss
□ Vision loss

Section Two – Respiratory medications and proper use:

1. Has your physician ever diagnosed you with any of the following respiratory conditions?

□ Asthma.
□ COPD or emphysema
□ Interstitial Lung Disease
□ Other Lung disease, please specify _____

2. How much you think you know about your disease?

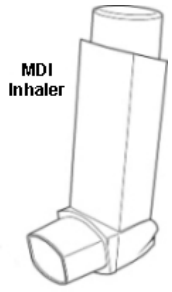
□ Nothing
□ Very little
□ Average
□ Good
□ Very well

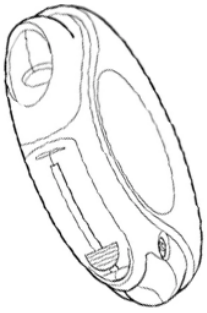
2. Have you ever been prescribed inhaled medication for your lung disease?

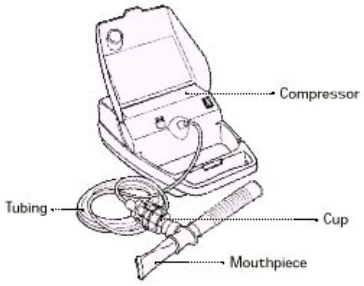
□ yes
□ no

3. Which of the following devices have you used for delivery of inhaled medications? (Select all that apply)

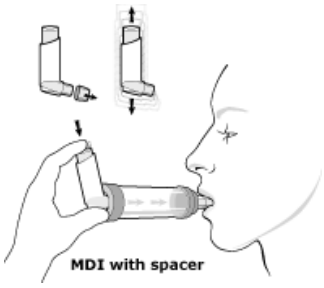
□ Metered-dose Inhaler □ Dry powder Inhaler □ Nebulizer

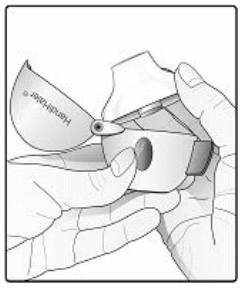






□ Metered-dose Inhaler with spacer □ DPI- Handihaler





4. How well do you understand the purpose of your inhaled medication?

1 2 3 4 5 6 7 8 9 10

No understanding Some understanding Completely understand

5. Please list the inhaled medication(s) you are currently taking and frequency of use, including if you use a spacer:

Medication	Device	Dose and frequency	Spacer

5. How confident are you that you understand the proper use and handling of your inhaled medication device(s)?

1 2 3 4 5 6 7 8 9 10

No confidence somewhat confident very confident

6. Indicate who prescribed your inhaled medication(s):

□ my pulmonologist
□ my primary care physician
□ allergist
□ Nurse Practitioner
□ Physician Assistant
□ others, please specify _____

7. Have you ever received education or formalized instruction on the proper use of your inhaled medication device(s)?

□ yes
□ no
□ I don't know.

If you answered yes to question 7, please answer the following two questions (8 and 9)

8. Please indicate who provided the education on proper device use. (Select all that apply):

□Pulmonologist
□Primary care physician
□Allergist

□Respiratory therapist
□Physician Assistant
□Nurse
□Pharmacist
□Other (please specify) _____

9. In what format was the education provided? (Select all that apply)
□ Verbal instruction
□ Written instruction
□ Written instruction with illustrations
□ Hands-on demonstration with sample device
□ Hands-on demonstration with your own device
□ Web-based education including written instructions and/or illustrations
□ Web-based education with video demonstration

10. Have you ever been asked by your prescribing provider or a member of their staff to demonstrate how you use your inhaled medication device(s)?
□ No
□ Yes, on one occasion
□ Yes, on multiple occasions

How long ago were you last asked to demonstrate how you use your inhaled device?
_____

11. What do you find most challenging about using your inhaled medication device?

_____

12. Please indicate the top five challenges that affect your ability to use your inhaled medication device properly (rank your top choices 1-5 and select any remaining choices that also apply):
☐ I have not received teaching on how to use it properly.
☐Although I have received some teaching, I cannot remember how to use it properly.
☐I cannot hold my breath during medication administration.
☐I cannot form a tight seal with my mouth around the device.
☐My hand strength and/or dexterity limit my ability to use the device properly.
☐I cannot coordinate my breath and hand action to administer the medication.
☐I cannot remember when to take my medication.
☐I cannot afford my medication.
☐Visual impairment limits my ability to use the device properly.
☐ I don't know if my inhaler is expired or not.

☐ I use different inhalers at the same time and I get confused.

☐Other (please specify):_____

Section Three: (patient preferences)

1. Please indicate your preference regarding the method of education about proper use of your inhaled medication device. How would you prefer to receive teaching?

□ Verbal instruction
□ Written instruction
□ Written instruction with illustrations
□ Hands-on demonstration with sample device
□ Hands-on demonstration with your own device
□ Web-based education including written instructions and/or illustrations
□ Web-based education with video demonstration

2. Please indicate your preferences regarding the setting in which you receive education regarding proper use of your inhaled medication device. Where and when would you prefer to receive teaching? Select all that apply:

Where?
□ Prescribing doctor's office
□ Primary care clinic
□ Community event
□ Pulmonary function lab or hospital
□ In the comfort of my own home
□ Other (please specify): _____

When?
□ At the time a new medication is prescribed
□ At a dedicated follow-up visit immediately after I have filled the prescription
□ At a routine follow-up visit after I have filled the prescription
□ At every follow-up visit after I have filled the prescription
□ Other (please specify): _____

3. Patient preferences regarding inhaled medication devices may vary according to several different factors. Please indicate the relative importance of the following factors in determining which device you may prefer:

Various factors	***Please choose a number based on the instructions above***
Device is portable	
Medication administration time is short	
Hand-breath coordination is not required	
Breath hold is not required	
Multiple dose device (I do not have to load each dose)	
Tight mouth seal is not required	
Regular device cleaning is not required	
Dosing is once daily	
Cost of device	
Brand name recognition	
Physician recommendation	

1 2 3 4 5 6 7 8 9 10
not important somewhat important very important

3. Do you want to continue using the inhaler?

□ yes

□ no

If no, please indicate the reason:
□ The cost is too burdensome.
□ I don't think it is helping me.
□ I don't know how to use it.
□ I have side effects from the inhaled medication.
□ other: _____

4. Do you mind using two different devices at the same time?

□ yes
□ no

THANK YOU FOR TAKING THIS SURVEY
WE WISH YOU ALL THE BEST